San Diego Pediatrics
6475 Alvarado Rd., Suite 120
San Diego, California 92120
Telephone: 619.583.6133 Fax: 619.583.0321

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(From our office)

Patient Information:

Name: _____ DOB: _____
Last First

Address: _____
Street City State Zip

Telephone: _____

To whom do you wish to release records?

Please provide person/facility, address, phone & fax number
WE MUST HAVE THIS INFORMATION

_____
_____
_____
_____

Release the following information:
□ Medical Record □ Immunizations Only
Specific Dates: From:_____ To:_____ All:____

Authorization and Signature:
□ I hereby authorize **San Diego Pediatrics** to release the records as described above. This authorization is valid for 90 days and may be revoked in writing at any time.

_____ _____
Parent/Guardian Signature Date

□ I consent to receiving records via an unsecured email. _____
Initials

Revised 01/15/16